

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012288	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/20/2013
NAME OF PROVIDER OR SUPPLIER LAMPLIGHT INN OF FORT WAYNE		STREET ADDRESS, CITY, STATE, ZIP CODE 300 E WASHINGTON BLVD FORT WAYNE, IN 46802		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint IN00139655.</p> <p>Complaint IN00139655-Substantiated, no deficiencies related to the allegations are cited..</p> <p>Survey Dates: November 19 & 20, 2013.</p> <p>Facility number: 012288 Provider number: N/A AIM number: N/A</p> <p>Survey team: Angela Strass, RN</p> <p>Census bed type: Residential: 125 Total: 125</p> <p>Census payor type: Other: 125 Total: 125</p> <p>Sample: 5</p> <p>Lamplight Inn of Fort Wayne was found to be in compliance with 410 IAC 16.2 in regard to the investigation of Complaint Number IN00139655.</p> <p>Quality Review 11/21/13 by Lisa McColly</p>	R 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE